Op-ed by Rep. Mike Thompson for *The Hill*

Rural districts, like mine in Northern California, have had a lot of trouble with Medicare managed care plans. During the late 1990s, Medicare Plus Choice plans – the original version of Medicare benefits provided through private insurance plans – pulled out of our districts and never looked back. Rural communities were deemed under-populated and unprofitable, and our beneficiaries were left confused and with limited healthcare options.

Today, the Medicare Plus Choice program is gone. Repackaged as Medicare Advantage, the program can now boast that all Medicare beneficiaries – regardless of where they live – have at least one private plan option serving their community. Expanding access to rural and historically under-served areas is a positive development, but, as with everything, we have to monitor the price of this progress.

Last month, the nonpartisan Medicare Payment Advisory Commission (MedPAC), the nonpartisan Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services' (CMS) Office of the Actuaries all released separate data showing that the government spends 12 percent more to provide care for beneficiaries in Medicare Advantage plans than traditional Medicare.

Reaction to this news has been varied, motivated as much by genuine policy concerns as politics. However, there should be one thing that every Member in this House can agree on: when an insurance provider is receiving government payments for a service that is costing, on average, 12 percent more than traditional Medicare pays for the exact same service, we should at least *review* that payment policy. If that review shows that the extra money isn't yielding extra results, then the payment policy needs to be revised.

This is particularly true for those plans with excessively high reimbursements, in some cases, over 150 percent of traditional Medicare costs. These outliers have the highest reimbursement rates and, seemingly, the least requirements. Known as private-fee-for-service plans, they are not required to have provider networks or conduct utilization management – calling into serious doubt their ability to provide any great value to Medicare through chronic disease management.

Make no mistake, we are talking about a lot of money. CBO has told us that capping Medicare Advantage payments at 150% of fee-for-service would yield $4 billion in savings over a ten-year period. Bringing Medicare Advantage payments in line with fee-for-service payments scores almost $160 billion in savings over that same time frame. Medicare Advantage payments represent significant expenditures, and it’s clear that a thorough review of the program is needed, as are comprehensive data from CMS.

Congress cannot accurately assess the appropriateness of payment rates without clear data on what plans are offering and what services beneficiaries are actually getting. For example, while CMS does tell us that the additional benefits offered by Medicare Advantage plans are valued at $86 per month, they aren’t telling us the rates at which seniors are actually using these services.

Similarly, CMS claims that Medicare Advantage plans are leaders in developing care management programs for chronic diseases. But, they aren't telling us how much plans are spending on these services or whether the services are improving patient outcomes. And yes, we've requested this information.

We do know that some Medicare Advantage plans operate efficiently. They provide both traditional and extra benefits at a lower cost than fee-for-service Medicare. A Congressional review of the appropriate data will allow us to figure out why these plans are more efficient than others. It will allow us to alter payments accordingly, if we decide that rewarding efficiency is our goal.

Let's be clear: Democrats do not support the elimination of the Medicare Advantage program. But it shouldn't be immune from scrutiny. Almost one-fifth of Medicare beneficiaries are enrolled in a Medicare Advantage plan, yet we have never reviewed this program to ensure we are getting what we pay for.

Under the guidance of Health Subcommittee Chairman Pete Stark, this review process has begun. He recently convened the first hearing on Medicare Advantage in the program's history, and additional hearings are forthcoming.

As the American population ages, we'll need to stretch every healthcare penny to the limit. We simply can't afford any wasteful spending. That means we'll need to put more effort into monitoring where healthcare funds are going and whether they are being spent wisely. And that's to everyone's advantage.